Accepted for publication in *Drugs and Alcohol Today* 17th June 2020 (published early online 31st July 2020).

DOI (10.1108/DAT-05-2020-0025)

Public Health participation in alcohol licensing decisions in England: the importance of navigating 'contested space'.

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Abstract

Purpose: The Police Reform and Social Responsibility Act of 2011, added 'health bodies' as responsible authorities in licensing and, in practice, Directors of Public Health undertook this role in England. Despite this legislation facilitating the inclusion of public health in partnerships around licensing, wide variations in involvement levels by public health professionals persist.

Design/ methods: This article is based on the findings from interviews that explored the experiences of public health professionals engaging with local established partnerships around alcohol licensing. Qualitative data were collected through twenty-one interviews in a purposeful sample of London boroughs. These data were combined with analyses of relevant area documentation and observations of fourteen licensing sub-committee meetings in one London borough over a seven-month period. Thematic analysis of all data sources was conducted to identify emerging themes.

Findings: This study highlighted the importance of successful navigation of the 'contested space' (Hunter and Perkins, 2014) surrounding both public health practice and licensing partnerships. In some instances, contested spaces were successfully negotiated and public health departments achieved an increased level of participation within the partnership. Ultimately, improvements in engagement levels of public health teams within licensing could be achieved.

Originality: The paper explores a neglected aspect of research around partnership working and highlights the issues arising when a new partner attempts to enter an existing partnership.

Keywords: Public health; alcohol licensing, contested spaces, professional identity.

Introduction

There is a large body of literature that clearly illustrates the challenges a partnership approach presents. Conflicts of interest, for instance around priority setting or use of resources, and the clash between different professional cultures are well documented (e.g. Hunter and Perkins 2014; Thom et al. 2013; Glasby and Dickinson, 2009). A particular issue, that has received less attention in the literature, is how a new professional group penetrates an established partnership and positions itself within the partnership dynamics. The newcomer risks being treated as an 'outsider'; as McGee Cooper (2005, p14) argued, 'new people may be treated as 'foreign and dangerous' and 'the tribe closes rank to defend against new ideas and cultural differences'. This paper considers how public health became a new partner in an established partnership around alcohol licensing in England. It uses the concept of 'contested space' to examine challenges faced by public health professionals and illustrates some ways in which the new partner attempted to legitimate their role and negotiate acceptance of their position within the partnership.

'Contested space' and partnership working

The concept of 'contested space' has been widely used particularly in geographical analyses, for instance, regarding the use of urban space (Kallus, 2016) or communal gardens (Schmelzkopf, 1995), or the 'ownership' of streets by particular social groups (Malone, 2002). It has also appeared as a way of understanding the dynamics of interaction within spaces such as food banks (Williams et al, 2016) and hospital wards (Savage, 1997). It has been used in examining non-physical space such as the incorporation of new technologies in educational curricula (Hesterman, 2011) or the totality of an organisation's areas of responsibility (Hunter and Perkins, 2014). The concept is rarely defined but it highlights and frames competing diverse interests and

priorities, the differential power of different social groups, and the politicisation of both physical and non-physical space.

It has been suggested that the notion of 'contested space' could be applied to public health, a domain of activity that ranges over global pandemic prevention, immunisations, epidemiology and alcohol prevention (etc.), creating a 'space' that is internally contested in relation to setting priorities and managing competing work streams (Hunter and Perkins, 2014). However, when agencies are required to work in partnership across policy and professional domains, the dynamics are no longer confined to negotiating internal conflicts of interest within the issue domain but now take place in a larger arena framed by a collaborative ethos.

The concept of 'contested space' provides a useful framework for rendering visible the dynamics that underpin the shift of public health into the role of a responsible authority in alcohol licensing and for understanding the impact of the shift on professional identity and practice cultures as public health practitioners negotiate their position within an existing partnership. The work of Gieryn (1999) also helps to reveal key aspects of the negotiation process and to examine how a profession that draws on 'science' as the foundation for its identity, its cultural credibility and its authority reacts when that credibility and authority are challenged. 'Boundary work' takes place within the contested space with the result, as Gieryn (1999, p237) suggests, 'rival parties manipulate the boundaries of science to legitimate their beliefs about reality'. Hall (2005) writing about boundary work, claimed it highlighted contrasts between rival professions by boosting beliefs and promoting expansion of the authority of one professional group over another. He suggested that these factors 'contribute to the culture of each profession as well as to the barriers between the professionals on a team, even without their awareness' (Hall, 2005, p190).

This paper examines how the role of public health in licensing decisions in England is constrained by public health's position within 'contested space' and how this impacts on professional identity and partnership working. We argue that public health departments can become partners in licensing decisions but in order to achieve this, successful navigation of contested space is required.

Public Health within alcohol licensing

A new alcohol Licensing Act for England and Wales was introduced in 2003 and implemented in 2005. The Act stipulated four objectives:

- The prevention of crime and disorder
- The prevention of public nuisance
- Public safety, and
- The protection of children from harm

  (Source: Home Office, 2018)

It was noted that, unlike in Scotland, the Act had no explicit health objective, an issue that raised considerable debate (Mahon and Nicholls, 2014; Local Government Association, 2016; Foster, 2016). However, mounting concerns over alcohol consumption and associated problems resulted in a subsequent spate of additional legislation designed to curb the sale and consumption of alcohol (Light, 2010; Royal Geographical Society, 2010). In 2006 the Violent Crime Reduction Act was introduced; in 2009 the Policing and Crime Act followed; in 2010 the Crime and Security Act was implemented and in 2011, the Police Reform and Social Responsibility Act was passed. These policies led to an expansion of professional groups charged with the task of overseeing local level decisions regarding licensing applications. Local groups designated as 'responsible authorities' had hitherto comprised the police, the local fire and rescue services, the local enforcement agency for the Health and Safety at Work Act (1974), the environmental health authority, the local planning authority, the body responsible for protecting children from harm, and the local trading standards authority.

As part of the Police Reform and Social Responsibility Act (2011) two new responsible authorities were created: the licensing authority and 'health bodies' (Local Government Association, 2013). Primary Care Trusts were the health body given this role and they could now:

- Make relevant representations to the licensing authority relating to new licence applications and licence variations.
- Make requests that the licensing authority review an existing licence.
- Make representations to the licensing authority regarding the potential cumulative impact of an application in an area where there was a special policy in place regarding cumulative impact.

(Source: LGA, 2013).

The Licensing Act (2003) is supplemented by 'guidance issued under section 182 of the Licensing Act 2003' for licensing authorities, for the "discharge of their functions under the 2003 Act" (Home Office, 2018). This guidance is periodically updated, with the most recent publication occurring in 2018.

Soon after, the Health and Social Care Act (2012) brought substantial reorganisation to the National Health Service. Primary Care Trusts (the newly appointed health responsible authority for licensing) were abolished; Clinical Commissioning Groups took over their role and a new national body, Public Health England, was established to protect and improve the nation's health and wellbeing and to reduce health inequalities (GOV.UK, 2019). Along with these changes, public health departments were transferred from the National Health Service, where they had been based since the 1970s, back to their historical location within local authorities. The role of responsible authority (health) now fell to Directors of Public Health (DPH) and, having been relocated to local authorities where the other responsible authority groups were based, this opened the door for greater engagement within alcohol licensing decisions and an expectation that public health would function in partnership with other responsible authorities.

These changes impacted on public health officials and their work in alcohol licensing in a number of ways. Alcohol licensing legislation was formulated largely within a crime and policing framework that was very different from the population health perspectives underpinning the work of public health departments where the focus was on lifestyle factors and evidence derived from aggregate data gathered from epidemiological studies (Berridge, 2013). The shift from being embedded in a medical environment to a local authority setting brought into question the knowledge base of public health as a sufficient rationale for decision-making, and working in partnership was challenging both internally, where alcohol issues vied for priority with other public health concerns, and in external relationships with other responsible authorities.

The addition of public health as a responsible authority within licensing was another role for practitioners within an already contested space. Internally, public health

officials have responsibilities across a wide range of issues relating to health improvement, health protection and healthcare (Department of Health, 2012). Areas of focus can range from – air quality, mental health, substance misuse, workplace wellbeing, sexual health services, child health, domestic violence and healthy eating, for example, with internal struggles for priority regarding resources. The new role in licensing had to vie with other priorities within this internal space of public health. In addition, for public health to enter into the existing licensing partnerships in local areas, it required additional resources and commitment to engaging in a multi-disciplinary network. This paper focuses on 'navigating' within the wider space of partnerships in local alcohol licensing.

Methods

To gain a deeper understanding of the experiences of public health professionals involved in alcohol licensing, different methods were employed.

A total of twenty-one interviews were completed within six London boroughs, twelve with public health professionals, four with representatives of other responsible authorities (licensing, police), and two with local authority councillors. In addition, one interviewee held a regional position and two representatives were from national organisations. Interviews were semi-structured and completed by telephone or skype; they lasted around one hour. Each interview covered a series of questions, broadly grouped into three key areas for investigation. These centred on:

- Policy process – Roles within the licensing process, decision-making processes, and definitions of acceptable evidence; views on national/local policy development.
- Partnership working - Perceptions of relationships with other licensing partners; perceived levels of influence of each partner and the goals of the partnership.
- Professional identity - Education and training background of respondents, views on the relocation of public health from the National Health Service to local councils.

Analysis of relevant documentation and observation of licensing sub-committee meetings was also undertaken. Documentation examined included the Statement of Licensing Policy produced by the eleven boroughs approached for inclusion within the

study. The Statement of Licensing Policy provides detail of how the licensing authority intends to operate procedurally and promote the licensing objectives in that area. Fourteen Licensing Sub-Committee meetings were observed (ten regular meetings and four special meetings where a review of a license/s had been requested). Field notes were completed, and the data obtained was grouped and common themes identified.

After transcription, every interview, and each piece of documentation (including field notes from the licensing sub-committee meetings) was analysed to identify key themes by applying the methods of Braun and Clarke (2006) on thematic analysis. These authors suggest that within thematic analysis there are two approaches, which they termed as inductive and theoretical. Within this study an inductive approach was used, with themes obtained from the data gathered. Each theme was allocated an overarching title such as partnership working, knowledge and professional identity. Themes identified subsequently were added beneath the overarching titles. Braun and Clarke (2006, p86) refer to this process as 'searching across a dataset – be that a number of interview or focus groups, or a range of texts – to find repeated patterns of meaning'. For more details of the methods see (Somerville, 2019)

Ethical approval for this research was granted by Middlesex University Health and Education Ethics Sub Committee.

Findings

Working in partnership: the 'ideal' and the reality

At a national level, organisations such as Public Health England promoted collaboration with other responsible authorities as key to licensing work. This message appeared to be adopted by some public health respondents. As one interviewee argued:

'*I would see licensing and public health pushing together now. We've got to be seen as one group, I think 'them and us' are gone, so it's one authority, it's one council'* (PH5)

But definitions of exactly what collaboration entailed or how partnerships 'worked' were lacking. For example, in the examination of the Statement of Licensing Policies, whilst five areas included dedicated sections on partnership working, three only briefly mentioned partnerships and three statements did not mention it. Even in areas where

partnership working was included in the text, there was no detail of how partnership work was evidenced in practice. The information obtained from Statement of Licensing Policies showed that the exact detail of work taking place was unclear. Clearly, a gap existed between the policy ideal and the practical reality of engaging in licensing partnerships.

Moreover, active engagement in partnerships was variable and accounts from respondents were contradictory – illustrating confusion around how the national policy 'ideal' on licensing was implemented in everyday practice. For example, as one regional representative commented:

'*There's still pockets where they're not doing anything, they've sort of abdicated their responsibilities to licensing, and where they just contribute occasionally. I think there is a frustration that there isn't more London local guidance, strategic vision and things like that. It is very much left up to the local boroughs, depending on their priorities. It's not very connected'* (R1).

Most public health interviewees agreed that partnership working was the policy ideal, but some felt that, at the local level, integrating into an existing partnership with established relationships was not achievable. One interviewee commented on closer working relationships between certain responsible authorities, which was attributed to a shared history of partnership working:

'*The core group are always licensing, the police, environmental health and trading standards. They are all very much embedded together and have been for years and years'* (PH5).

A tendency for professional groups to continue to work within their own professional frameworks was reported as impeding collaborative efforts and as reflecting differences in perspectives of the issues and the responses needed:

'Environmental health, health and safety, planning and trading standards they'd be looking at it from a very different perspective. If they have an issue, it would be a very different issue from what we have so there wouldn't necessarily be the reason for that collaboration there' (PH8)

Moreover, public health respondents noted that there was variable involvement of other responsible authorities. They identified planning departments, the fire brigade and children's services as responsible authorities with low engagement and suggested a range of reasons for this, such as planning operating under their own legislation and the fire brigade and children's services lacking resources to allow full participation. Thus, public health professionals indicated that there was still a decision to take over whether they should try to become embedded within the existing partnership or whether to withdraw.

A notable example of this dilemma emerged from the interviews and observations in one area. Public health professionals spoke during interviews about how important partnership working was within licensing; but from observation of licensing sub-committee meetings it became apparent that there was actually very little contact between public health and the licensing authority in that area. No public health professionals attended meetings during the seven-month observation period suggesting low engagement within the licensing partnerships in that area. This information was confirmed during interviews with two local councillors who also stated that there was not a large amount of involvement from public health.

Barriers, relationships, and professional identity

A number of barriers to partnership working emerged from the data – many of them linked to perceptions of professional identity and the status of public health professionals in relation to the professions in other responsible authorities.

Divergent goals

One example was the perceived lack of clear goals for public health involvement in licensing. This was seen as a barrier to engagement and was contrasted to other responsible authorities, such as the licensing authority and the police, where objectives were clear. During interviews, each respondent initially reported they were clear about 'their' goals but over the course of all interviews, it became apparent that goals differed by professional group. For example, public health respondents mentioned goals focusing on reducing alcohol related health harms. The police stated their goal/s was either the promotion of the licensing objectives or reducing crime and disorder and the

councillors stated their goal was to encourage business development balanced with a safe night-time economy in their areas.

One public health interviewee responded to a question on goals being shared across all responsible authority groups by stating:

'*I'd say it's shared across all responsible authorities. I think generally we are all sort of aiming for the same thing, which is safe and responsible alcohol licensing'* (PH8).

However, this statement was then contradicted during the same interview when the respondent said:

'*But in terms of work with the licensing sub-committee and the licensing department, you know we work well with them but certainly we're not necessarily working towards the same end'* (PH 8).

The one goal most frequently mentioned across responsible authority groups was the promotion of the licensing objectives. The police, trading standards and the licensing authority all vocalised this as their primary goal. At the same time, each responsible authority group had additional goals that were specific to their individual professional group. Public health respondents occasionally mentioned promotion of the licensing objectives, but, as noted above, their main goals related to health objectives. As one Public health interviewee stated:

'Public health, at least in my borough, are working to reduce alcohol related health harms so that is a slightly different goal from the other responsible authorities' (PH4).

Perceptions of role

Some respondents argued that a health-based licensing objective would assist public health by legitimising the role of public health in licensing decisions. Comments were made such as:

'*I think it would give us a much stronger seat at the table. Having a fifth health based licensing objective can't fail to help give us a bit more weight and be seen a bit more as an equal partner…, then health data would have to be a primary consideration, because you can't have a licensing objective without any kind of weight behind it*' (PH7).

Feeling that their position was not yet seen as 'legitimate' was reflected in respondents' comments regarding their relationships with the other responsible authorities. In discussing the issue of equality in the partnership, for example, considerable unease emerged regarding gaining a foothold in what was seen as an established power hierarchy:

'There is a different relationship with each responsible authority group. I would say with licensing, I think that's probably been more of a challenge and I think at times it doesn't feel that public health is an equal partner' (PH2).

Study participants from other responsible authority groups also seemed confused over the potential role that public health could play within licensing. For example, opinion was split over whether public health professionals should play a supportive role and therefore be subservient to other responsible authorities or whether public health should have equality. This was evident in one borough, where the role outlined for public health by the licensing authority was one of support and of supplying data. This supportive role was operationalised by the requirement that submission of representations against licensing applications by public health could occur only in conjunction with other responsible authorities, instead of stand-alone representations. During observation of licensing sub-committee meetings, there was one joint submission with public health, the Police and Trading Standards. The public health evidence consisted of information on the number of public order offences that resulted in ambulance call outs within one ward and the number of schools within 500 metres of the premises; but the main focus of the representation was on the sale of counterfeit items without duty payment. At the licensing sub-committee meeting, this submission was presented by representatives from the police and trading standards without a public health professional in attendance.

At the same time, while public health professionals indicated that they felt excluded from becoming fully engaged in partnerships, there were indications that, in some instances, public health were self-excluding themselves from licensing work. In one area, the public health department reported no involvement in alcohol licensing work. This decision had been taken by the public health department themselves and did not appear to be due to any form of exclusion by the licensing authority or any other

responsible authority group. In this area, the licensing authority reported actively trying to engage the public health department.

Professional identity and boundaries

The power relationship and related professional boundaries around different areas of work also emerged as problematic for partnership working in discussions on the value placed on public health contributions and interventions. For instance, it was reported by public health respondents that if they presented information that was seen to 'belong' to another professional group, they met resistance:

'Where there is an objective that says crime and disorder, the police have the main lead for this. What you see, is when public health presents this information, there are pushbacks from others, and particularly from the legal side' (N1).

In effect, this implied that presentation of information regarding crime and disorder infringed on the professional identity and remit of the police responsible authority. At the same time, public health respondents suggested the type of evidence they could offer was rather different, and not as well received, as the evidence used by other responsible authorities. It was suggested that:

'*Its personal stories and testimony that the licensing subcommittee pay attention to not to data and statistics*" (PH1) and that "*it's not about the numbers and confidence intervals, it's about how forceful you make the argument and your professional judgement*' (PH10).

One public health professional suggested that participation in licensing partnerships was '*a combination of politics, advocacy, lobbying and data*' (PH6).

On the other hand, public health respondents were aware that their professional identity and what they thought of as 'evidence' set them apart from the other responsible authorities. As one respondent noted:

'*The purist idea that we would have as epidemiologists and as scientists about evidence and the way we would conceptualise evidence, is quite different to the more persuasive and advocate-based approach that one might take from a licensing point of view*' (PH10).

Definitions of evidence

In addition, there were differences relating to the contents of acceptable evidence assigned by the various responsible authority groups. Public health professionals were clear that their evidence consisted of public health data. This presented them with problems since there was an assumption within the licensing committee that health-related evidence had to link directly with the premises listed on the application and to one of the four current licensing objectives. The finding that public health evidence was viewed as less compelling than evidence submitted by other responsible authorities and labelling public health data as not specific enough (not premises specific) represented a major obstacle to effective engagement within licensing decisions.

Another comment reflected the challenges faced in the transition of public health from health authorities to local authority administration.

'I think public health still see themselves, it's a bit strange isn't it, as medical and clinical, they don't see themselves as involved in legislation or regulatory. We still have this battle' (PH5).

Thus, differences in professional identity and working practices and the need to find a footing in an established partnership added to difficulties of collaboration in alcohol licensing partnerships. In summing up, one public health respondent described their relationships with other responsible authorities as a series of marriages of convenience and stated that it was going to take some time for them to be fully integrated within licensing partnerships (PH11).

Working in a 'contested space'

The reports from interviewees indicated the difficulties experience in entering and working in a 'space' already occupied by established partners. The data illustrated how the dynamics of interacting within this space reveal the existence of a hierarchy regarding the legitimacy, perceived usefulness and adequacy of the knowledge and evidence contributed by different partners. This study highlighted how aims and objectives are framed in different, and sometimes conflicting, ways by different professional groups; and it points to the importance of policy and organisational contexts as providing the parameters within which partnerships are formed and enacted.

Partners responded in different ways, including the new public health partner who either opted to withdraw completely or to varying degrees, attempt to navigate the space.

Navigating the space

Although the interviews tended to emphasise the barriers to partnership working, this research also identified common features in areas that appear to have achieved greater levels of participation in licensing decisions by navigating the contested spaces surrounding licensing and public health work. The visibility of alcohol-related problems was one key factor. In areas with a larger than average night-time economy, that experienced visible problems around excessive alcohol consumption, the engagement of public health in licensing partnerships appeared greater. The involvement of the Director of Public Health, acting as a champion for this work, was important in providing motivation to work around licensing and bridge differences between partners in terms of perceived goals and priorities.

Allocation of dedicated resources often accompanied by a 'champion' was another important factor. Areas which had dedicated resources to licensing work, with at least one senior public health individual, who was motivated to increase participation within licensing decisions, appeared to engage more fully. For example, in one area, it was reported that a post had been created within environmental health that worked around public health objectives for licensing. A third factor included willingness to adopt a variety of approaches to providing information. A few public health professionals reported moving away from reliance purely on public health statistical data towards, for example, using concerns voiced by residents, to initiate discussions with other responsible authorities over policy options, such as borough wide recommended opening hours for licensed premises. They were, therefore, prepared to adjust the nature and content of the arguments they presented and the rationale for their proposals.

Finally, there were examples of individuals who appeared to have navigated the contested space, achieving this by extending their professional boundaries to foster increased involvement within licensing work. In some cases, staff created opportunities

to work closer with other responsible authorities, such as setting up responsible authority meetings to discuss applications or physically sitting with the licensing team for part of the working day. As one respondent stated:

'*I'm a bit of a person who works across boundaries and pushes people, a bit less corporate maybe*' (PH6).

Discussion

Working across boundaries in order to address factors labelled as 'the wider social determinants of health', had been cited as a positive reason for public health to move back into a local government setting (Green, 2014; DoH, 2012, 2011; HM Government, 2010). This was expanded to include public health utilising their role as a responsible authority within licensing to potentially influence the availability of alcohol in each area.

As the above sections have shown, public health respondents reported considerable difficulties in engaging in established licensing partnerships, expressing concern that their ways of working were at odds with the working practices and approaches of other responsible authorities and that they had to tread carefully to avoid crossing professional boundaries. In particular, their identity as health-related professionals who saw themselves as working with a body of knowledge based on science was contrasted to other responsible authorities who were seen as operating with a different understanding of the issues and a more legal, regulatory and advocacy based approach.

Within the licensing 'space' there was, therefore, a perceived hierarchy of types of evidence and modes of working deemed suitable to licensing decision-making and perceived differences in the legitimacy of different responsible authorities to operate within the space. Different responsible authority groups appeared to compete to ensure prominence for their priorities and to protect the boundaries of their spheres of professional practice (Gieryn, 1999). Public health lacked familiarity of navigating within this hierarchy and may not even have been aware of, or accepted, its existence.

Public health departments, in addition to working within this external contested space around licensing, also faced contested space within public health work itself, where they were obliged to balance competing work agendas and priorities. Thus, licensing work

constituted only a small part of their overall role and internal priorities undoubtedly impacted on the time and resources available to engage within an external partnership. As a result, public health professionals also used 'boundary work' as a means of both avoiding additional responsibilities, and as a way of protecting their existing roles and status as scientists (Gieryn, 1999).

Other barriers to collaboration, commonly experienced in partnership working (e.g. McQuaid, 2009), included lack of agreement and clarity over goals. In this research public health professionals were primarily working towards a broad goal of improving population health, while the licensing authority, the police and trading standards primarily worked towards the promotion of the licensing objectives.

However, a more deep-seated barrier emerged relating to the professional identity and institutional embedding of public health professionals within medicine and the National Health Service. It is a reasonably recent decision to allow non-medical professionals to become employed in senior positions within this profession (Evans and Knight, 2006). During this research it was suggested that the inclusion of professionals with a non-medical background in public health was expected to introduce a wider view of health beyond a medical focus on illness and disease. Non-medical individuals, it was argued, were likely to have a better understanding of the social determinants of health model, which included licensing work. The move of public health from the National Health Service to local government could also be seen as another strategic shift towards broadening the base of public health. Together, these developments had an impact on the professional identity of public health professionals.

Phillips and Green (2015, p493) described local government as being a 'creature of stature that exists as a complex web of legislation created through individual acts of national parliament'. This is very different to traditional public health working arrangements within the National Health Service. Licensing processes operate within a quasi-legal framework, which is new to public health practitioners. This meant that public health professionals, tasked with participating in licensing decisions, needed to establish the legitimacy of their role and to negotiate challenges from other professionals regarding the appropriateness and adequacy of the knowledge and expertise they had to offer in making decisions around alcohol licensing.

There were few examples of how individuals or authorities had responded to difficulties in partnership working. However, a small number of participants in this study described altering their approach to licensing decisions away from reliance on data towards working across boundaries, as 'boundary spanners'. – 'people and organisations working together to manage and tackle common issues' (Williams 2011: p27). Within the field of licensing, where multiple professional groups need to collaborate within a contested space, boundary spanners play an important part in facilitating navigation and increasing involvement in licensing decisions.

Having a shared history has been found in other studies to facilitate partnership working (Hunter and Perkins, 2014, 2012; Baggott, 2013; Glasby et al, 2011). Similarly, in licensing, there is a tradition of partnership working between some responsible authority groups, most notably between the licensing authority, the police and trading standards. It may be that over time, public health will succeed in becoming embedded within this traditional partnership.

Conclusion

The findings from this study suggest that without resources, high level 'champions' and ongoing work by public health professionals at local and national levels, participation within licensing decisions will continue with variable levels of engagement and with limited success in contributing to the wider goal of reducing health inequalities.

However, if public health professionals continue to develop alternative ways of working and of overcoming the 'contested' nature of the licensing space and the hierarchy within it, legitimisation of their role and their place in licensing decision-making may become stronger. At the same time, in planning and executing structural changes, politicians and policy makers need to recognise the risks, as well as the potential benefits, of change and ensure that professional and organisational stakeholders at local as well as national levels are fully prepared and supported to manage new ways of working.

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Acknowledgements: This paper is derived from PhD research, jointly funded by Alcohol Change UK and Middlesex University.